Kentucky Board of Nursing

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Compliance Section, Consumer Protection Branch
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Monthly Self Report

Participant Name: _____

☐ KARE for Nurses Program
☐ Probation

Instructions: Please fill out this form **COMPLETELY** and mail the completed form to the Compliance Section, Consumer Protection Branch, by the tenth (10th) of each month. The original form is being supplied to you. Make a supply for your use by copying this one. Please copy the form front to back.

Address: ☐ I have changed my address and/or phone number since last report.	Participant Case #: Home Phone #: ( ) Work Phone #: ( )

Report for the month of _____, 20___ **Sobriety Date:** _____

1.	Have you had any change in your address, employer, work site address, employment status, employment shift or hours of work, work site monitor, or work restrictions or responsibilities? ☐ No ☐ Yes *If yes, please explain.*
	THERAPY ATTENDANCE AND INVOLVEMENT (Required: ☐ Yes ☐ No)
2.	Therapist's Name and Phone #:
3.	How long have you been in counseling with this person?
4.	Number of sessions scheduled per month: ( ) # attended this reporting period ( )
5.	Progress (*issues and how you feel about progess*):
	PSYCHIATRIC ATTENDANCE AND INVOLVEMENT (Required: ☐ Yes ☐ No)
6.	Psychiatrist's Name and Phone #:
7.	Frequency of Visits:
8.	Medications and Doses:

TREATMENT/AFTERCARE/PROFESSIONAL GROUP (Required: ☐ Yes ☐ No)	
9.	Program Name Facilitator Name and Phone #:
10.	Location:
11.	Length of Participation:
12.	Progress:
CADUCUS/HEALTH CARE PROFESSIONALS ATTENDANCE AND INVOLVEMENT (Required: ☐ Yes ☐ No)	
13.	Name of Facilitator:
14.	Number of required meetings per week: ( ) # attended during this reporting period: ( )
15.	Progress in Group (*i.e., what are you getting and giving to group*)
12-STEP MEETING REQUIREMENT	
16.	Number of required meetings per week? ( ) # attended this reporting period: ( )
17.	Type of Meeting (*i.e., speaker, open discussion, etc.*)
12-STEP INVOLVEMENT	
18.	What step are you on?
19.	Service Involvement/Other Progress (*i.e., make coffee, etc.*)
20.	Within the month, have you experienced cravings or using dreams? ☐ Yes ☐ No (If yes, please explain.)
21.	Have you relapsed? ☐ Yes ☐ No If the answer is yes, have you reported the relapse to your case manager? ☐ Yes ☐ No Explanation:

COMPLIANCE REQUIREMENTS	
22.	Do you have a sponsor? ☐ Yes ☐ No How long? Name of sponsor:
23.	How often do you have contact with your sponsor? (*i.e., 2 x week, 4 x month, etc.*)
24.	Total number of contacts with sponsor this reporting period ( ) # Face-to-Face ( ) # Phone ( )
MEDICAL TREATMENT	
25.	Physician's Name: Phone #: ( )
26.	Reason for Care:
27.	Is the physician familiar with your recovery program? ☐ Yes ☐ No
28.	Identify any prescription drugs or over-the-counter drugs taken this month and the reason for use.
29.	Has any documentation been sent by the physician ☐ Yes ☐ No If not, attach a copy of the prescription or a note from the physician.
SOCIAL/RECREATIONAL	
30.	Activities:
FINANCIAL/LEGAL	
31.	Status:
OTHER	
32.	Comments or concerns regarding NCPS:
33.	Comments or questions for case manager:
ADDITIONAL COMMENTS:	
Participant Signature:	**Date:**

1/06/04 jmc